

April 19, 2023

COVID-19 Public Health Emergency Waivers

The Public Health Emergency (PHE) was established in January of 2020, by the Department of Health and Human Services (HHS) under Section 319 of the Public Health Service Act, in response to the COVID-19 pandemic. Since then, the PHE has been renewed every 90 days without interruption. A number of waivers and flexibilities were put in place during the PHE in concurrence with the Centers for Medicare & Medicaid Services (CMS), which allowed for changes to many areas of health care delivery during the pandemic. In many cases, health care providers received maximum flexibility to streamline the delivery of services and allow access to care during the PHE. Based on current trends related to COVID-19, the Biden Administration and HHS have decided to end the PHE on May 11, 2023. This will lead to a majority of waivers expiring, with a few exceptions for waivers that will continue on for a predetermined amount of time, and waivers that may be made permanent through CMS. CMS has provided a [roadmap](#) that explains in detail these different waivers, which we have summarized below.

1. State Licenses and Workforce Waivers

a. Nursing Services

482.23(b)(4) – ends with PHE

CMS waived this requirement, which called for the nursing staff in either a hospital or critical access hospitals (CAHs) to develop and keep current a nursing care plan for each patient.

482.23(b)(7) – ends with PHE

CMS also waived the requirement that a hospital shall have policies and procedures in place, establishing which outpatient departments are not required to have a registered nurse present.

These waivers were implemented to allow nurses increased time to meet the clinical care needs of each patient and allowed for the provision of nursing care to an increased number of patients.

b. Requirements for Facility Hiring and Use of Nursing Aides

483.35(d) – terminated

CMS waived the requirement that a facility may not use any individual working in the facility as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services, and that individual has completed a training and competency evaluation program, or a competency evaluation program. This waiver allowed facilities to employ individuals beyond four months, in a nurse aide role even though they might have not completed a state approved Nurse Aide Training and Competency Evaluation Program (NATCEP).

2. Scope of Practice

a. Physician Services

482.12(c)(1)-(2) and (4) – **ends with PHE**

CMS waived the requirement that Medicare patients be under the care of a physician. This allowed hospitals to utilize other practitioners to the fullest extent possible.

b. Anesthesia Services

482.52(a)(5), 485.639(c)(2), 416.42 (b)(2) – **ends with PHE**

CMS waived the requirement that a certified registered nurse anesthetist (CRNA) must be under the supervision of a physician, instead allowing CRNA supervision to be at the discretion of the hospital, and state law. This waiver applied to hospitals, CAHs, and ambulatory surgical centers (ASCs) and allowed CRNAs to function to the fullest extent of their licensure.

c. CAH Personnel Qualifications: CNS and CNP

485.604(a)(2), §485.604(b)(1)–(3) – **ends with PHE**

CMS waived the requirement, which provided for certain personnel qualifications including that a clinical nurse specialist (CNS) must be a person who holds a master's or doctoral level degree in a defined clinical area of nursing from an accredited educational institution, and that a certified nurse practitioner (CNP) must be a registered professional nurse who is currently licensed to practice in the state, who meets the state's requirements governing the qualification of nurse practitioners, and who meets one of the following conditions: Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates, has successfully completed a one academic year program, and has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements of a master's or doctoral level degree, and has been performing an expanded role in the delivery of primary care for a total of 12 months.

Removing these federal personnel requirements allowed CAHs to employ individuals in these roles who both meet state licensure requirements and provide maximum staffing flexibility.

d. CAH Staff Licensure

485.608(d) – **ends with PHE**

CMS waived the requirement that staff of a CAH must be licensed, certified, or registered in accordance with applicable federal, state, and local laws and regulations. This waiver provided maximum flexibility for CAHs to use all available clinicians possible.

e. Responsibilities of Physicians in Critical Access Hospitals

485.631(b)(2) – **ends with PHE**

CMS waived the requirement for CAHs that a doctor of medicine or osteopathy be physically present to provide medical direction, consultation and supervision for the services provided in the CAH. CMS retained one component of the requirement: that a physician be available through direct radio, telephone or electronic communication for consultation, assistance with medical emergencies, or patient referral. This allowed a physician to perform responsibilities remotely, and allowed CAHs to use CNPs and physician assistants (PAs) to the fullest extent possible.

f. Staffing and Staff Responsibilities: Physician Responsibilities

491.8(b)(1) – this flexibility is currently set to return to pre-PHE rules at the end of the calendar year that the PHE ends (12/31/23), but CMS is exploring options to make this flexibility permanent

CMS waived the requirement that physicians must provide medical direction for the clinics or center's health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners, and only to the extent permitted by state law. The physician, either in person or through telehealth and other remote communications, continues to be responsible for providing medical direction for the clinic or center's health care activities and consultation for the health care staff, and medical supervision of the remaining health care staff. This waiver allowed rural health centers and federally qualified health centers to use nurse practitioners to the fullest extent possible and allowed physicians to direct their time to more critical tasks.

g. Physician Services

483.30 – ends with PHE

CMS waived the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents, and instead allowed visits to be conducted via telehealth.

h. Physician Delegation of Tasks in SNFs

483.30(e)(4) – ends with PHE

CMS waived the requirement that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gave physicians the ability to delegate any tasks to a PA, CNP, or CNS, but specified that any task delegated under this waiver must continue to be under the supervision of the physician.

i. Physician Services: Frequency of Physician Visits

483.30(c)(3) – ends with PHE

CMS waived the requirement that all physician visits (not already exempted in §483.30(c)(4) and (f)) must be made by the physician personally. The waiver modified this provision to permit physicians to delegate any required physician visit to a CNP, PA, or CNS who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state and performing within the state's scope-of-practice laws.

3. Telehealth

a. Eligible Practitioners

410.78 (b)(2) – ends 151 days after the conclusion of the PHE

CMS waived the requirement that specified the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. This waiver expanded the types of health care professionals that can furnish distant site telehealth services to include health care professionals who were previously ineligible including, physical therapists, occupational therapists, speech language pathologists and others, to receive payment for Medicare telehealth services.

b. Audio-only Telehealth for Certain Services

410.78(a)(3) – ends 151 days after the conclusion of the PHE

CMS waived the requirement that video technology be used for certain services involving telehealth, and instead allowed for the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services.

c. Telemedicine

482.12(a) (8)–(9), §485.616(c) – will end with PHE

CMS waived the requirement that when telemedicine services are furnished to a hospital's patients through an agreement with a distant-site hospital, the agreement specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements of this section with regard to the distant-site hospital's physicians and practitioners providing telemedicine services, and ensure that when telemedicine services are furnished to the hospital's patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of services to the hospital and, as such, furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services.

These waivers made it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital, which allowed for increased access to necessary care for hospital and CAH patients, including access to specialty care.

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